

HEALTH INTAKE FORM: RETURNING PATIENT

Date: _____

Patient Name: _____ Contact Email: _____

Welcome back to Capital District Pediatric Cardiology. Please take a few minutes to update us on some health questions regarding your/your child's patient visit with us today. Answer as best as you can on both the front and back of this sheet. If more space is needed, please feel free to use the space on the backside of this sheet. Your doctor will go over everything with you during your visit, and answer all of your questions. PLEASE RETURN THIS FORM TO THE FRONT DESK PRIOR TO YOUR VISIT. Thanks!

Reason/Main Concern For Your Visit Today: _____

Specialist Physicians (other than the Primary Physician) Caring for the Patient:

1) _____ 2) _____ 3) _____

Patient's Current Medications:

Medication Name	Dose/Amount	Frequency/times per day
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

Patient's Allergies to Any Medications:

Medication Name:	If allergic, type of reaction
1) _____	_____
2) _____	_____

Pharmacy Preferred For Prescriptions:

Name: _____
 Address (or location): _____
 City: _____
 State: _____
 Phone: _____

Past History: Changes Since The Last Visit:

Surgeries (Type and Date)	Hospitalizations Overnight (Reason and Date)
_____	_____
_____	_____
_____	_____
_____	_____

Family History: Changes Since The Last Visit:

Any family member:

born with a congenital heart defect?	Yes	No
with a history of an irregular or abnormal heart rhythm?	Yes	No

Any family history of:

heart disease/heart attack/surgery before the age of 50?	Yes	No
cardiac or unexplained sudden death before the age of 50?	Yes	No

(over)

Patient Review of Systems:

Any current symptoms with (if yes, circle the specific symptom):		
Systemic: such as fever, weight gain/loss, loss of appetite	Yes	No
Head: such as headaches, sinus pain	Yes	No
Neck: such as pain, stiffness, swollen glands	Yes	No
Eyes: such as with vision, redness, pain, swelling	Yes	No
ENT: such as speech, nasal, hearing, swallowing trouble	Yes	No
Dental: such as with teeth, gums	Yes	No
Heart: your doctor will ask you about this directly		
Lungs: such as cough, wheeze, phlegm, shortness of breath	Yes	No
Abdomen: such as vomiting, diarrhea, pain, swelling	Yes	No
Kidneys: such as bloody, frequent or painful urination	Yes	No
Endocrine: such as thirst, temperature sensitivity, hair loss	Yes	No
Blood problems: such as anemia, bleeding	Yes	No
Muscle and Joints: such as swelling, pain, weakness	Yes	No
Neurologic: such as developmental delay, seizure, migraine	Yes	No
Skin: such as rashes, sores, blueness	Yes	No
Allergy/Immunity: such as chronic infections, allergies	Yes	No
Psychosocial: such as school problems, behavior problems	Yes	No

Are there any other concerns or questions for today's visit?

Please use the space below for any additional information.

PLEASE RETURN THIS FORM TO THE RECEPTIONIST AT THE FRONT DESK
(EVEN IF NOT COMPLETED) PRIOR TO YOUR VISIT.